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Overview

- Background to program
- Goals
- Model of Care
- Client outcomes
- Conclusions

RDNS

Profile

Each month:
- 6,300 active clients
- 1,500 new referrals
- Intake from the acute sector: 850 clients
- An average of 44,000 visits

Each year:
- Care for more than 24,000 people
- Over 530,000 visits and consultations
- 10,000 referrals from public and private hospitals
- Call Centre receives 582,000 calls

We have great outcomes:
- 71% of RDNS clients have met their goal of care when discharged.
- ICCOP clients: 51% reduction in unplanned Emergency Department presentations and hospital admissions and a 37% reduction in total bed days for older people with complex chronic conditions.

Based on

- **The EverCare Model** – United Health Group –
- USA (50% reduction in hospitalisation rates – same mortality rates – reduction in use of prescription drugs)

- **The Community Matron Model** – developed by the NHS – based on care coordination and planning designed to reduce unplanned emergency hospital admissions and reduce the length of hospital stays.

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THE LATEST RESEARCH SHOWS THAT WE REALLY SHOULD DO SOMETHING WITH ALL THIS RESEARCH

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Background

Partnership between:

- RDNS (3 Clinical Practice Consultants)
- RDNS Direct – 24 hour Contact Centre
- Adelaide Western GP Network
- 3 GP Practices (currently 17 GPs and growing)
- TQEH (Emergency Dept and Geriatrician)

Aim – not to duplicate services.

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Goal

- To assist clients who are identified as having complex health care needs **AND** who are deemed at risk of unplanned hospitalisation.
- Early intervention to prevent further deterioration.
- Designed to link clients to appropriate services within their own community.

Right Care, Right Time, Right Place

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Target population

- 65 years +
- ATSI 45 years +
- Multiple complex health problems
- Frequent presentations to TQEH (or at risk of)
- Patients of GP clinic involved in the program
- Are not receiving other similar services e.g. DVA, EACH
- Willingness of client/carer to receive the service

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Model of Care

- Relationship building between partners and with clients/patients.
- Assistance to navigate the health care system.
- Service links.
- Early clinical intervention.
- Planned hospital admissions and discharges.
- Enhanced communication with secure website.
- Prompt notification of changes to care with remote access.

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Clinical Case Management

- Continuity of care - key element
- Early clinical intervention due to recognition of deterioration
- Link to the acute sector – access to OASIS
- Access to advice and case discussion with Consultant Geriatrician

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Clinical Case Management

- GP focussed – all CPCs have forged good working relationships with GPs – mutual respect and access to Medical Director.
- Prompt intervention from GPs as required
- Opportunity to arrange planned admissions and be involved in discussing client's progress whilst in hospital and be fully involved in discharge planning

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Clinical Case Management

- 24 hour specific research based health advice available to client and their families
- Links to local services and service providers
- Internet access and web based site to allow all partners to access current care plans and events

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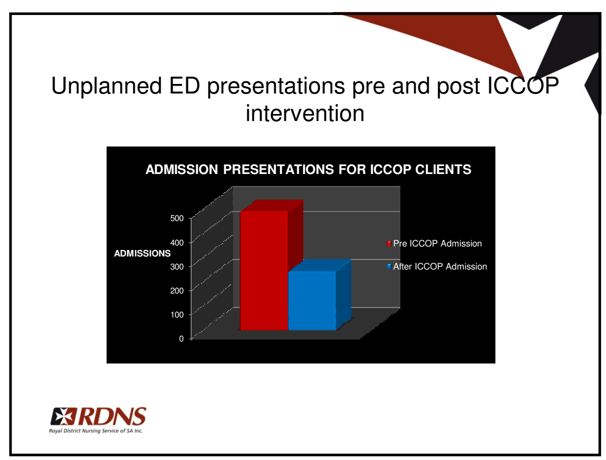
E record

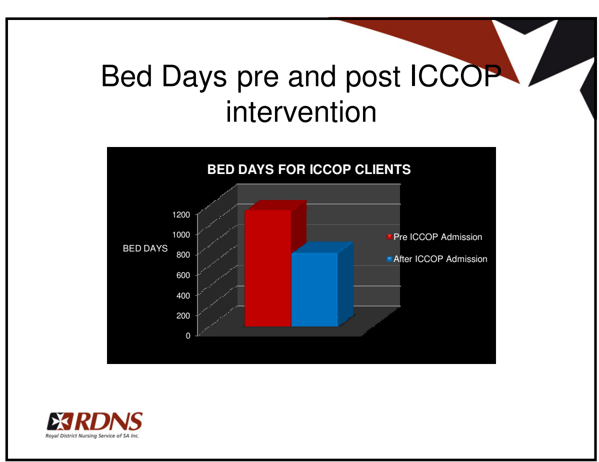
Outcomes to date

- 169 clients admitted to the program in the first 11 months
- By end of July, 139 current clients
- 66% of clients over 80 years of age
- 27% of clients have either a diagnosis of dementia, memory loss or mental health issues
- 70% of clients are from a CALD background - 50% from Italy
- The majority of referrals are from GPs

Unplanned ED presentations pre and post ICCOP intervention

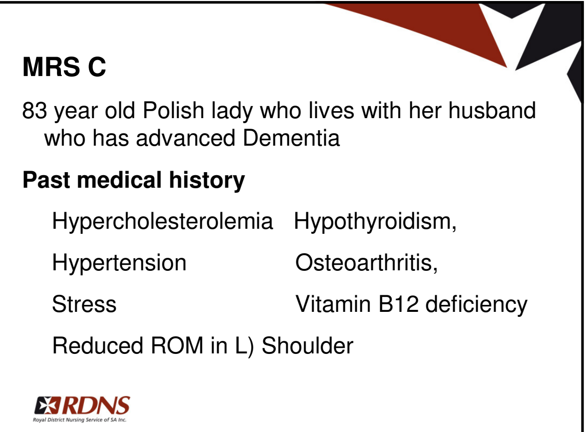


Bed Days pre and post ICCOP intervention



Case Studies

MRS C



Routine visit in order to take to view a day care facility. On arrival, she stated that she did not feel well.
She thought she had 'sun stroke'

Mini Mental = 19/30 on previous assessment.
BP - 136/90 Pulse – 96

Agitated and irrational in her thought processes

Urinalysis pH 5 Leucocytes +++; Nitrates; Blood++

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Discussed with GP immediately

?Urinary Tract Infection

Commenced Trimethoprim 300mg daily (evenings) for 7 days.

Outcome:

One week later, all symptoms had resolved.

Urinalysis pH 5 - NAD

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Key Issues

As she was known to the ICCOP nurse, it was recognised that this behaviour was not usual for her despite existing Dementia. Early identification of 'abnormal behaviour' and probable prevention of rapid decline into illness.

Likely prevention of admission of two people to hospital – as husband is totally reliant upon wife for all care and attention.

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MR B

Admitted to ICCOP due to non compliance with other services and multiple unplanned presentations to ED (x 4 in previous 9 months).

Was being seen by RDNS weekly for leg ulcer management.

Evidence of marked self neglect.

Previously refused Dom Care intervention.

Lives alone as his wife resides in an RCF due to advanced Dementia.

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Past Medical History

Peripheral vascular disease

Atrial fibrillation with Pacemaker insertion

Hypertension

GORD

Gout

Multiple prescribed medications which he did not always remember to take.

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Management

Visited weekly to gain trust and attend to wound management

Facilitated a planned admission to QEH due to:
1. bleeding from his gums
2. extensive oedema of both legs
3. exacerbation of his leg ulcers
4. depressed mood with evidence of self neglect.

In hospital, was given
1. Vitamin K
2. IV Frusemide
3. 2 units of packed cells

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Outcome of TQEH admission:
- ↓ oedema
- leg ulcers improved
- commenced on an anti-depressant
- commenced on Thyroxine 25mcg daily (later increased to 100 mcgs)
- full medication review

Transferred to St Margaret's Hospital for two weeks and discharged home

Referral made to Dom Care to install grab rails around the home – (previously refused)
Arranged for the OT to attend the house whilst ICCOP nurse was present.

Team was able to encourage Mr B to consider the installation of a grab rail beside the steps into the back door. This was eventually agreed upon and installed.

Client Outcomes

Since being home – leg ulcers have healed.

Remains in his own home with weekly visits to monitor.

Often has small blisters on his legs – these are drained and dressed as soon as they appear.

Coping well with medications with support and remains essentially well.

Key Issues

Mr B remains in his own home – functioning reasonably well but requires ongoing monitoring and nursing intervention on occasions.

Has **NOT** presented to ED at all since being admitted to the ICCOP program – 9 months.

Client has greatly improved quality of life and he remains reasonably positive despite his wife dying 12 weeks ago.

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Conclusions

Australia's ageing population is set to peak in the number of people aged over 85 years in 2012 – so the time to act is now.

Develop systems that emphasise the importance of measures and is focused on outcomes rather than outputs.

Collaboration between primary care, acute care and community care is effective in keeping older people healthy at home.

It is imperative that Australia systematically addresses and validate the efficacy of models such as ICCOP and secures them into the health and community service infrastructure.

Thank you

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